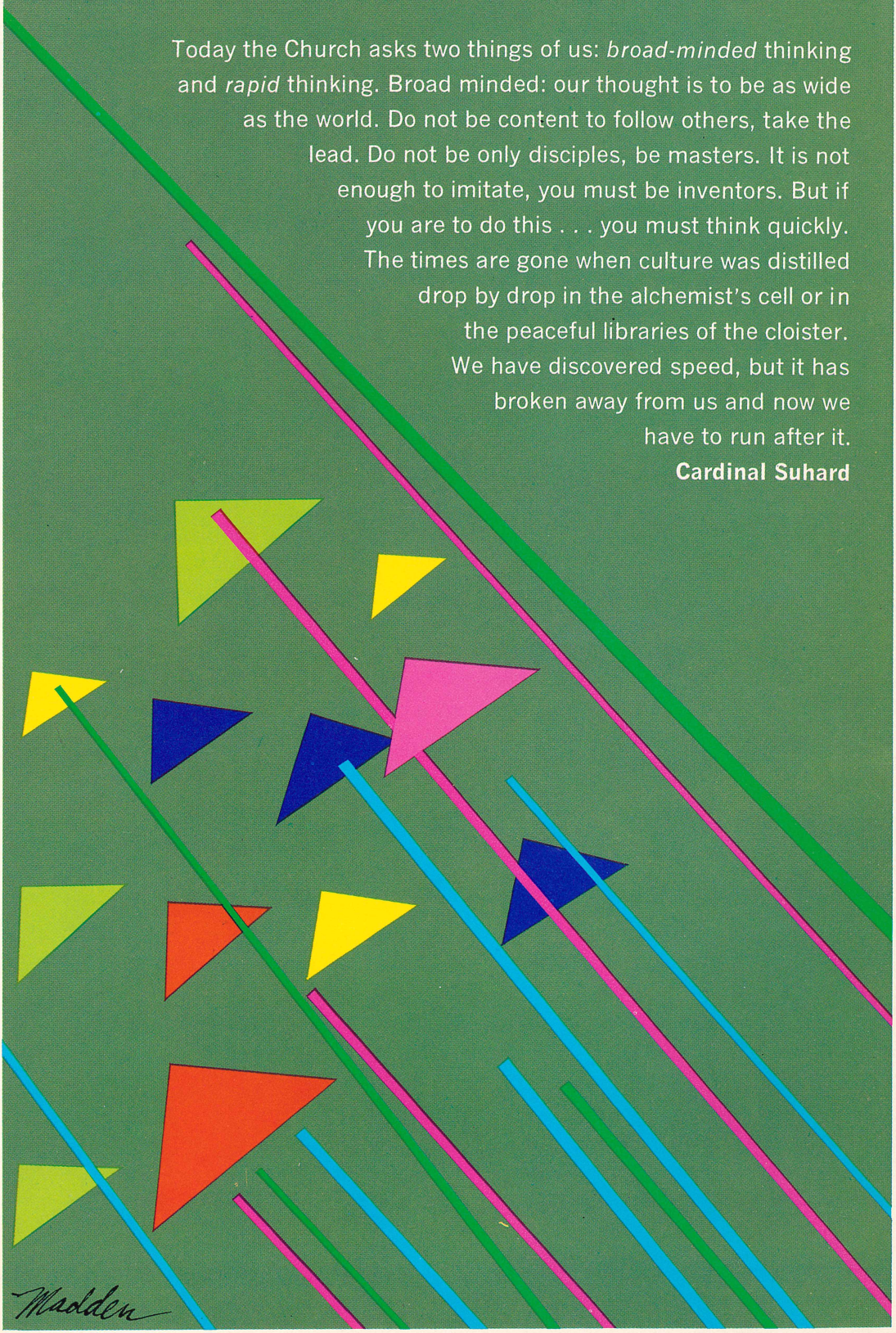
medical missionary

the role of the hospital
in the emerging nations

JANUARY-FEBRUARY, 1963

Today the Church asks two things of us: *broad-minded* thinking and *rapid* thinking. Broad minded: our thought is to be as wide as the world. Do not be content to follow others, take the lead. Do not be only disciples, be masters. It is not enough to imitate, you must be inventors. But if you are to do this . . . you must think quickly. The times are gone when culture was distilled drop by drop in the alchemist's cell or in the peaceful libraries of the cloister. We have discovered speed, but it has broken away from us and now we have to run after it.

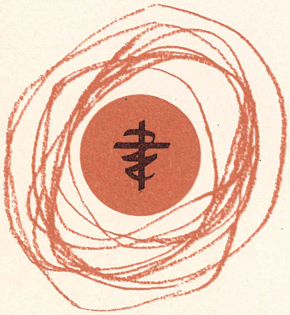
Cardinal Suhard



Our Theme 1963

Through the years, the Medical Mission Sisters' desire to serve the sick where the need is greatest has taken them into remote rural areas and fast developing capital cities, in both East and West, North and South. It has established them among Christians and non-Christians, among Buddhists and Bantus, Hindus and Muslims . . . It has involved them in building a chain of hospitals wherein they may set the pace for professional competence, coupled with Christian devotedness.

As each new country in Asia and Africa comes to maturity, as health standards are slowly and painfully raised, as life expectancy increases, the Medical Mission Sisters' apostolate takes on new dimensions. Once it was a question of simply serving the sick, of working for the people in medically less developed areas. Now it is also a matter of providing large training centers for nurses, midwives, technicians, etc., where young nationals may have the opportunity for professional education. It is a question of working side by side with them, joining forces to implement national health schemes.



Last year in the pages of the MEDICAL MISSIONARY we took you, our readers, to some of our interesting village hospitals . . . this year we would like to introduce you to another side of our apostolate, our large city institutions in India, Pakistan, and Venezuela . . . where the fast changing social, economic, and political conditions make even greater demands on the hospital and the Sisters who staff it . . . It is in these larger centers that some of the greatest contributions have been made towards raising the standards of health for the newly emerging nations.

THE medical missionary

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Cover Photo: Nurses' capping ceremony, Holy Family Hospital, Kurji, India.

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role of the hospital in the asian emerging nation

by Sister M. Frederic, M.D.

"Hospital trends in Asia and Africa can be regarded as another example of the interrelationship between the evolution of medicine and that of human society.

These trends have followed, therefore, the familiar pattern of development in accordance with the needs of society and the facilities that are available for such development."

This is the opening paragraph of Dr. Karunarantne's article in Dr. Joseph Owens' recent book "Modern Concepts of Hospital Administration" (1962).

Dr. Karunarantne, the president of the Ceylon Medical Association, sums up the situation and shows the plans and achievements of developing nations in the health field.

At present, due to the "immediate social need to alleviate disease and suffering" . . . "the concept of health care is largely based on treatment of disease and immunization campaigns." Research as yet is in its early stages in a few large centers in the big cities. In the developing nations, hospital care is for the most part government (and to a lesser degree private) enterprises. The prevailing method is to have large centers with specialty services in the cities, particularly in association with medical schools, as well as hospitals providing different levels of care, on out to the "periphery" with its twenty-bed rural hospitals with associated outdoor dispensaries in the surrounding villages. This is the method followed in India.

In strategic southeast Asia, India is one of the outstanding developing nations. As early as 1934, plans were drawn up for the systematic economic development of India. Since independence, three successive Five Year Plans have been implemented "to raise living standards and open out to the people new opportunities." The long term objective was to double the *per capita* income and to raise consumption standards by a little over 70% by 1977. A little over 1/5 of the budget in the present (third) Five Year Plan is for the social services, which includes health.

The measure of development of a nation can be made in many ways other than *per capita* income. We could discuss communications and the increase in radio stations from 6 at the onset to 29 in 1961, or the increase in production of food by 6% in one year, between 1960 and 1961, in spite of sectional droughts and floods. Another measure is increased industrialization. Three new steel plants went into operation during the first 10 years of independence, and the heavy machine industries doubled their production during the same ten year period. During these same years over 2,500 new hospitals and dispensaries were built, bringing the number to 11,894. And in the last 5 years alone, India's 65 medical colleges increased their admission capacity from 3,660 to 7,900 students. However, there is still a tremendous amount of work to be done to make the 450 million inhabitants of India a health-conscious nation.

In the health field alone: the death rate was found to have dropped from 25.9/1000 in 1951 to 21.6/1000 in 1961, and the life expectancy rose from approximately 32 to 42 years. The national budget for health has been more than doubled in this same period. Although clinical malaria as reported from the hospitals has fallen from 10.8 to 0.6% between 1953 and 1961 due to a concerted anti-malarial campaign, T.B. is still estimated as claiming 5,000,000 patients yearly, VD at 20 million, and leprosy at 2 million.

Yesterday, one of my former patients of five years ago, was admitted for an operation. When he came to the examining room, the first thing he said was, "This hospital does you (the Sisters) credit. It is really set up to give first class medical care." I was pleased that he could say that unprompted. But this is not just a pat on the back. Since 1926, our Society has been one of the pioneers in providing professional medical care in India, taking part in the overall problem of reducing infant and maternal mortality, and lowering the morbidity due to malaria, T.B., leprosy, cholera, typhoid, anemia, malnutrition, and the like, and in raising the life expectancy.

This has been done in India, for example, through a system of hospitals and dispensaries, ranging from the single dispensary unit in Poona, to our village hospitals, such as Thuruthipuram, Kodarma, and Mandar, to the city hospitals in Delhi and Kurji.

Our young Sisters of different nationalities, are being prepared to play their role in the hospitals of India. The M.D.'s and R.N.'s that were sufficient in 1926, are being supplemented by higher studies—for the doctors, specialties, especially OB-Gyn. and general surgery, and for the nurses, degrees in nursing education and public health.

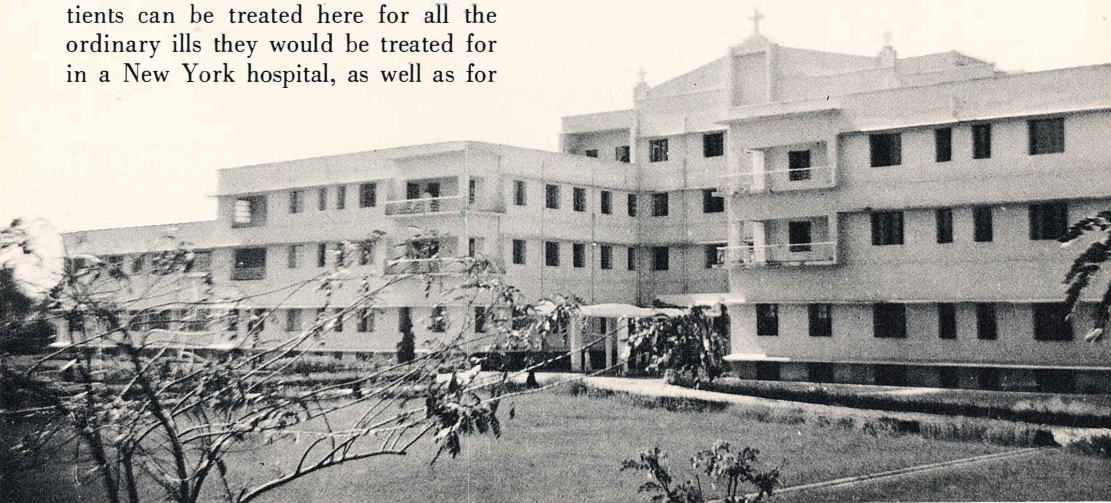
With the change in the times, the level of training and care is also changing. The bush mission hospital of yesterday is being slowly superseded by adequately equipped hospital centers with affiliated dispensaries. Like all of our city hospitals, Kurji has its own rural and local public health program, discussed elsewhere.

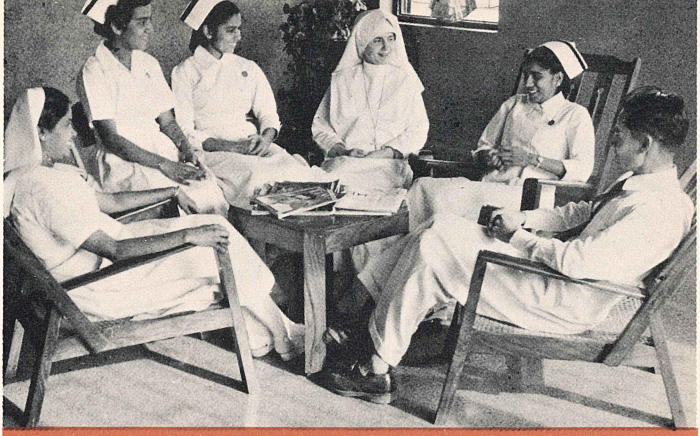
In 1939 Medical Mission Sisters first came to Patna, India, to set up a temporary hospital in the old Cathedral and associated buildings. In April, 1953, ground was broken at Kurji for the present hospital. It was formally opened Nov. 19, 1958, by His Excellency, Dr. Zakir Hussain, Governor, then, of the State of Bihar.

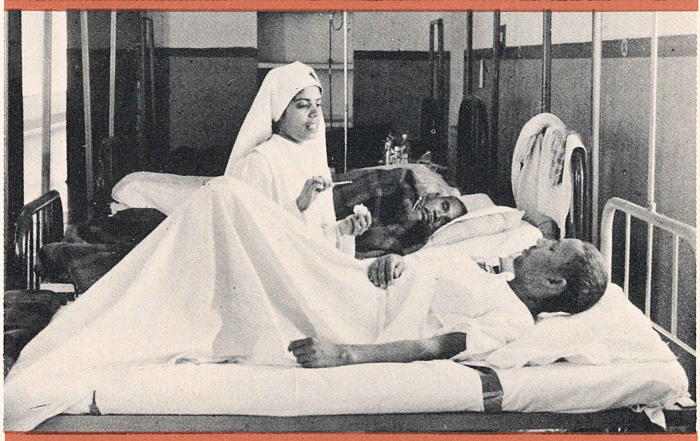
Kurji is organized to meet the medical and surgical needs of this area. Patients can be treated here for all the ordinary ills they would be treated for in a New York hospital, as well as for

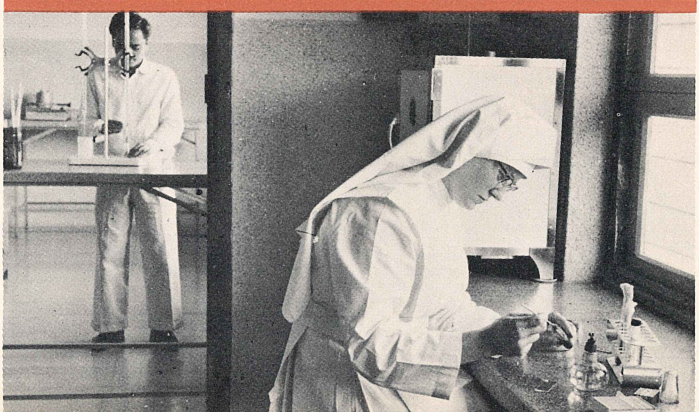
Kurji Holy Family Hospital (below) is a 200-bed general hospital on the banks of the Ganges in Patna. It is one of 8 hospitals conducted by the Medical Mission Sisters in India. 95% of the staff both professional and non-professional is of Indian nationality . . . Some of the former are Indian Medical Mission Sisters.

Right now, pneumonia, heart disease, and meningitis account for a goodly number of medical patients. In September, cholera and typhoid lead the list. Winter is the "season" for gastric resections and smallpox epidemics.









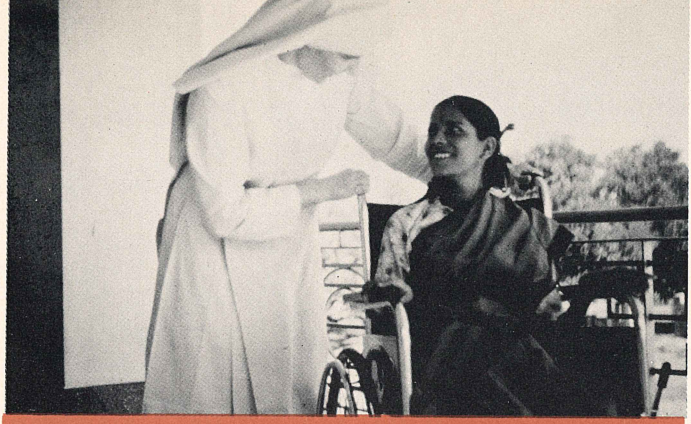
TOP TO BOTTOM

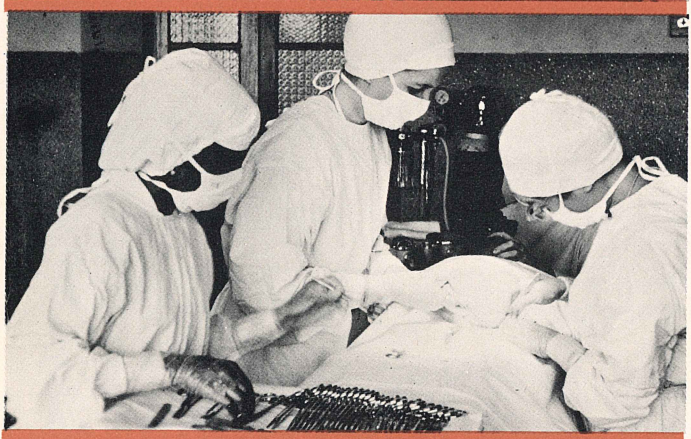
Sr. M. Carol, Administrator, Kurji Hospital with small group of staff nurses at the weekly staff meeting.

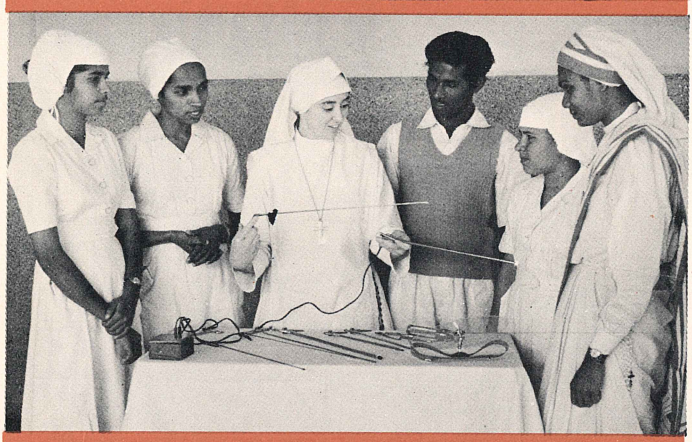
Sr. M. Frederic, M.D., Medical Sup't of hospital, explains triple vaccine to a mother of pediatric patient.

Sister M. F. Michael, R.N. caring for ward patients.

Sr. M. Evelyn, M.T. in Lab. Rich and poor receive same treatment.







TOP TO BOTTOM

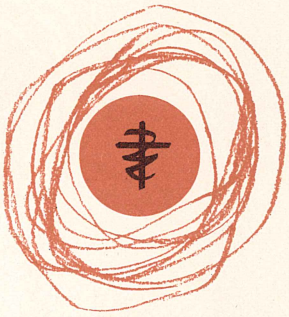
Sr. M. Carmel, B.S.N. with T.B. patient, Kurji Hospital.

Sister surgeons. Sr. M. Frederic, M.D. (left) and Sr. M. Pia (right) operate in Kurji Hospital O.R.

Sr. M. Bernardine, O.R. Supervisor, shows students how to set up for bronchoscopy.

Sr. Jane Frances, Pharmacist, is Vice President of Bihar Pharmaceutical Association.

Kurji Holy Family Hospital is one effort to bring professional medical care to the needy . . . to teach it to others who will carry it to other parts of India as well . . . It is a modern translation of the parable of the Good Samaritan.



such local diseases as cholera, typhoid, tetanus, and filaria. Adequate facilities for general surgery and for obstetrics and gynecology are available. There are six full time doctors, as well as consultants in some of the specialties. For other specialties, the services of the local medical college hospital can be utilized when existent, or the patient can be referred elsewhere, for instance to Ranchi for psychiatric care at the Indian Mental Hospital.

A school of nursing and a school of midwifery are an integral part of Kurji Holy Family Hospital. While almost 1/4th of the graduates of our schools are Sisters who will return to their own communities to carry on medical work elsewhere, lay graduates may remain on to become members of the graduate staff and in turn participate in the teaching programs. A continued in-service program is maintained, as well, for the nurses' aides. The doctors, too, have weekly medical meetings on ward or other current problems.

The role of our hospital in the emerging nation can thus be summed up, as here in Kurji—the care of the sick, the education of others in this same type of care, the teaching of the prevention of sickness, not only to in-patients, but reaching out to the villagers served by its public health program, in an ever-widening circle of service and love.

YOUR WILL +

can help the Medical Mission Sisters bring health and healing to the sick and suffering of mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $.....for its purposes,"

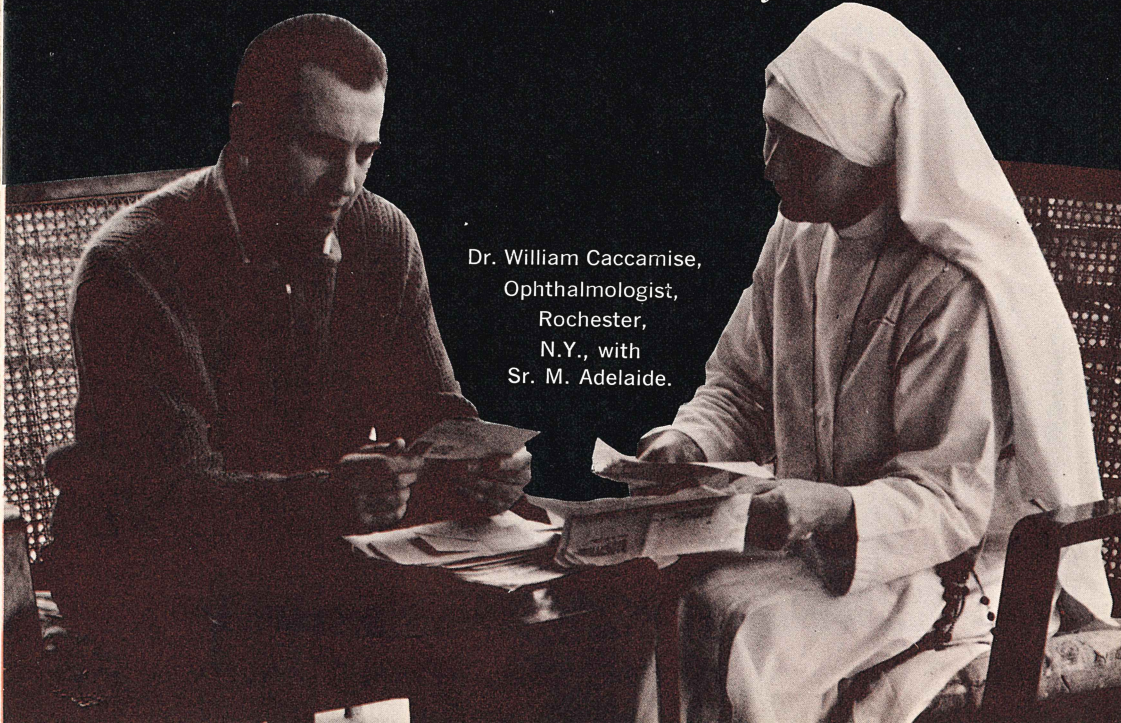
If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.

Telephone calls, telegrams, letters, postcards, messengers began descending on Kurji Holy Family Hospital in December. The Third Eye Clinic was really going to be an all-India affair: the Punjab, Kerala, Bombay, Hyderabad, Madras, Assam, Goa, Pondicherry, every state in India, and Burma.

So on New Year's Day, 1961, at noon when Doctor William C. Caccamise of Rochester, New York, landed at the Patna airport, Sr. M. Adelaide, Superior of Kurji Holy Family Hospital, and Sr. M. Frederic, M.D., Medical Director, could tell the Eye Surgeon that India really *welcomed* him on this, his third visit.

During the three months of the Free Eye Clinic, while Doctor Caccamise treated 4,500 new out-patients, 700 in-patients, and performed 650 operations, lectured to nurses—Sister M. Adelaide, who handled the Doctor's public relations, had to know the answers.

INTERVIEW WITH DR. CACCAMISE *by Sister M. Adelaide*



Dr. William Caccamise, Ophthalmologist, Rochester, N.Y., with Sr. M. Adelaide.

Dr. C.: Who do you think just came to see me? Remember the post office clerk whom we took care of during Christmas week of 1951? He had a terrible infection after cataract surgery elsewhere. We cleared up the infection, eviscerated the eye, then removed the cataract from the other eye. He is still working in the post office with one artificial eye, and excellent vision in the other.

Sr. A.: Has your method of cataract surgery changed in ten years?

Dr. C.: Naturally, improvement in surgical equipment has modified the technique. This year I am using all catgut sutures—there is not the tedious and painful removal of stitches. Of course, we could not afford to use these if we had to purchase them—they are all donations from U.S. surgical supply companies.

Sr. A.: So many people have waited in blindness several years for you to do their cataract surgery, they are afraid—

Dr. C.: Yes, by suturing the wound after surgery, the percent of successful cataract cases could be raised from its present 50-60% to 97 or 98%.

Sr. A.: Some surgeons are inclined to remove only so-called "ripe" or mature cataracts. How do you decide when to operate?

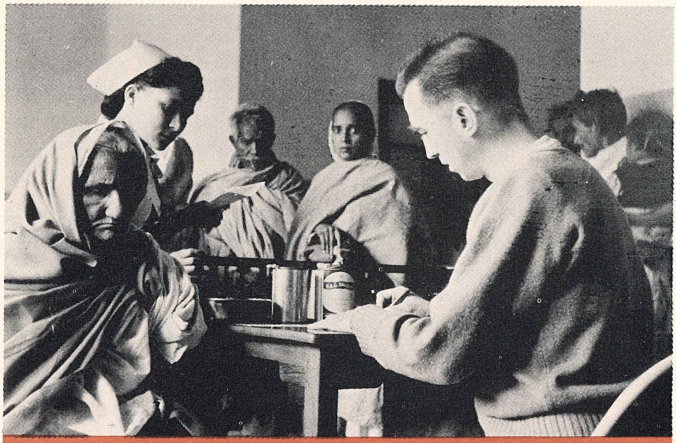
Dr. C.: I operate when the patient's vision is inadequate for his purposes. This may be quite independent of the maturity of the cataract. This approach is extremely important since certain types of cataracts may never become mature, but may still totally incapacitate the patient from a visual point of view. There is probably not another hospital in India where the type of surgery done here is being performed. My friends in the U.S., and people here in India, do not believe that we work here at Kurji with the same conditions as are available at home. You Medical Mission Sisters deserve credit because you know and provide the sanitary and aseptic conditions required for modern medicine and surgery.

Sr. A.: What do you think are the greatest contributions that can be made by our nurses in the prevention of blindness?

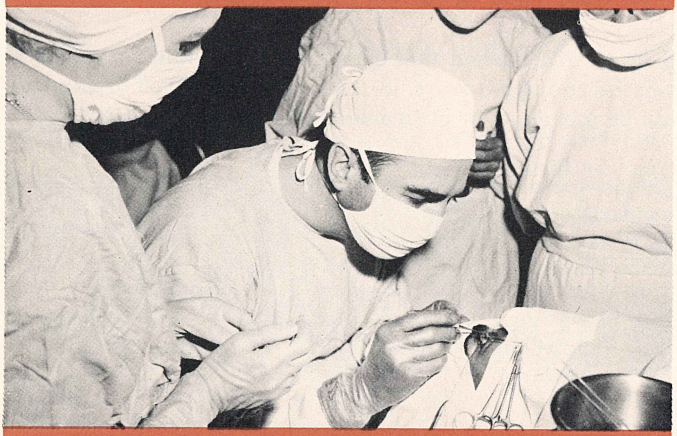
Dr. C.: Indian nurses could prevent a tremendous amount of blindness if they could teach the public four things:

(1) Importance of vaccination against smallpox. Day after day in the out-patient department we see case after case of blindness due to this disease.

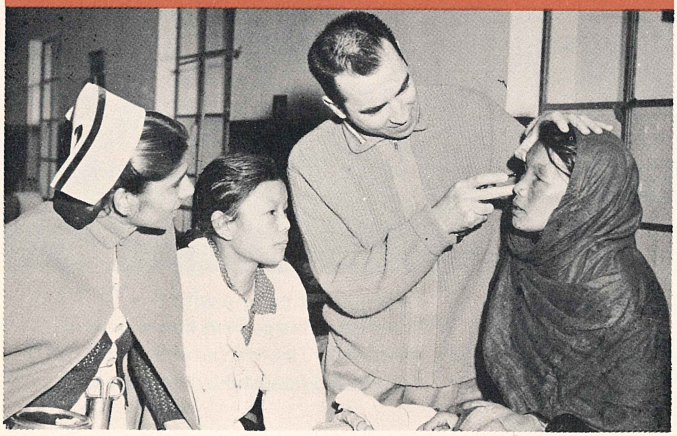
(2) Trachoma, a disease related to dirt—a virus infection which, if untreated, often results in blindness. Really it is a socio-economic problem. In 1951 I examined all the Catholic school children in schools in the surrounding area of Patna district. There were no cases of trachoma among these children of the upper class of society, or those living in sanitary conditions.



Eye clinic, Kurji. In three months Dr. Caccamise (at desk) treated 4500 new out-patients, 700 new in-patients, performed 650 operations. The clinic is held at his expense. U.S. drug companies give medicines.



Dr. Caccamise completing the corneal transplant. Sr. M. Frederic, M.D. assisting. Sr. M. Francis Xavier, M.D. watching.



Dr. Caccamise demonstrating to nurse in charge of Out-Patient Department. This young woman (of 32 years) has a cataract. Her other eye, totally blind is already atrophic. Doctor examines between 70 to 100 patients a day.

In the villages, 60% were infected. Treatment is very simple, and the disease easily arrested—oral use of sulfa drugs.

(3) Keratomalacia—a Vitamin A deficiency—literally the cornea may melt away overnight. It becomes soft, perforated, resulting in blindness. This occurs almost exclusively in children. The answer to this is vitamin therapy.

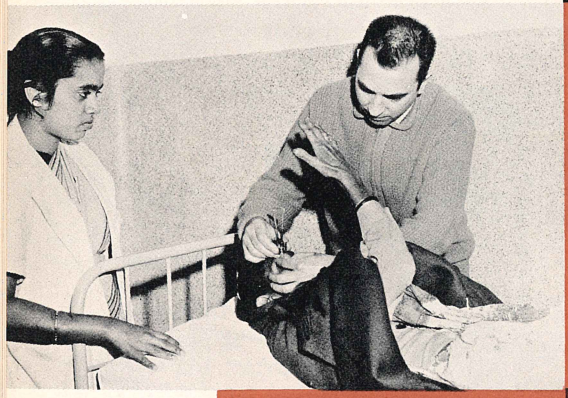
(4) The most important thing for adults is to enlighten people in regard to the possibility of glaucomas—a condition in which the pressure in the eye is increased and there is a resultant degeneration of the nerve of sight. It occurs in 2% of persons over 40 years of age (earlier here in India); if relatives have the disease the chance of its developing is 4%.

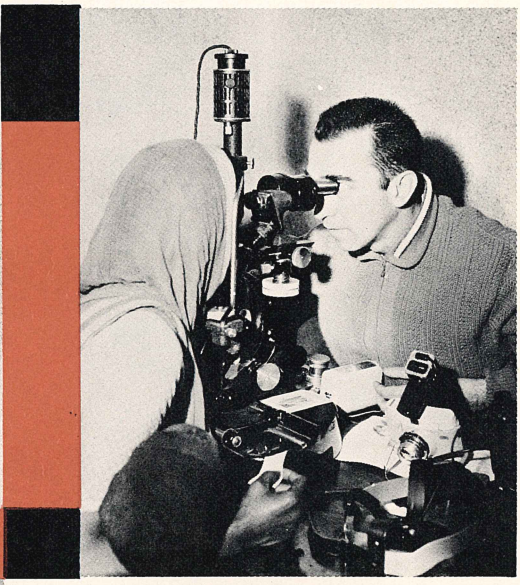
Sr. A.: What have you found to be the highest incidence in inherited abnormalities?

Dr. C.: To list a few: *retinitis pigmentosa,* a progressive degeneration of the retina; dystrophy, degeneration of the cornea; congenital cataracts, etc. We see many of these cases daily in the out-patient department. They cannot be helped.

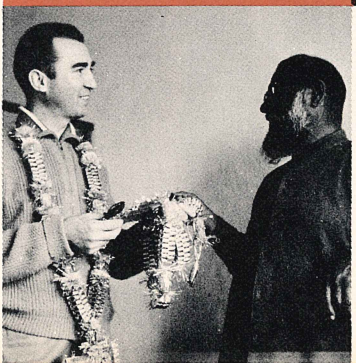
In summing up—I recommend that each and every child should be examined betweeen the age of 3-5 years. In this way many a type of blindness-*amblyopia* could be prevented or overcome. If detection of this condition is

Dr. Muthana, one of the House Residents, watches while Doctor Caccamise measures intraocular pressure on a glaucoma patient.





Examining a patient with the slit lamp. This patient had severe glaucoma. The instrument was donated to hospital by Dr. Caccamise.



Grateful patients came to the airport to see Dr. Caccamise off for home. One man garlanded him with a *mala* made of roses.

made before the age of 6 years, there is a good chance of preserving and improving poor vision.

Sr. A.: Few people seem to have a correct idea of just what has been made possible during the last ten years in regard to Keratoplasty or corneal grafting. You belong to the Rochester, N. Y., Eye Bank. Please make some statement on this subject.

Dr. C.: An Eye Bank is a place where eyes which have been willed by individuals are deposited after their death. They must be kept in a thermos and used within 72 hours. The Eye Bank in Rochester was set up for:

(1) Corneal transplant—fresh corneas must be used. Corneas preserved in glycerin are used for emergency work in case of accidents, etc.

(2) Vitreous—to preserve vitreous aspirated from the eye for use when necessary in surgery.

(3) Eyes to be used for pathological study and improvement of surgical techniques.

Sr. A.: India really has a need for such banks and doctors are writing asking how to set one up.

Dr. C.: I will be happy to advise them. The procedure is simple. Of course, it presupposes that there are highly trained eye surgeons to make use of the bank.

Sr. A.: Doctor, the Sisters, the nurses, the staff, and patients whom you have been able to help, thank you for the opportunity of working with you for a third time. We all owe a debt to the U. S. drug and surgical companies for making this free Eye Clinic possible. India and Kurji Holy Family Hospital hope to see you again.

† R.I.P.

Please pray for our benefactors recently deceased:

Most Rev. Archbishop Aston Chichester, Salisbury, Rhodesia

Most Rev. Archbishop John J. Swint, Wheeling, W. Va.

Msgr. John Fraser, Scarboro, Canada

Rev. Raymond McGowan, Kansas City, Mo.

Rev. Thomas Ohm, O.S.B., St. Ottilien, Germany

Rev. Bro. Benedict, C.S.C., Chittagong, Pakistan

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Mrs. Cecilia Courtney, So. Ozone, N.Y .

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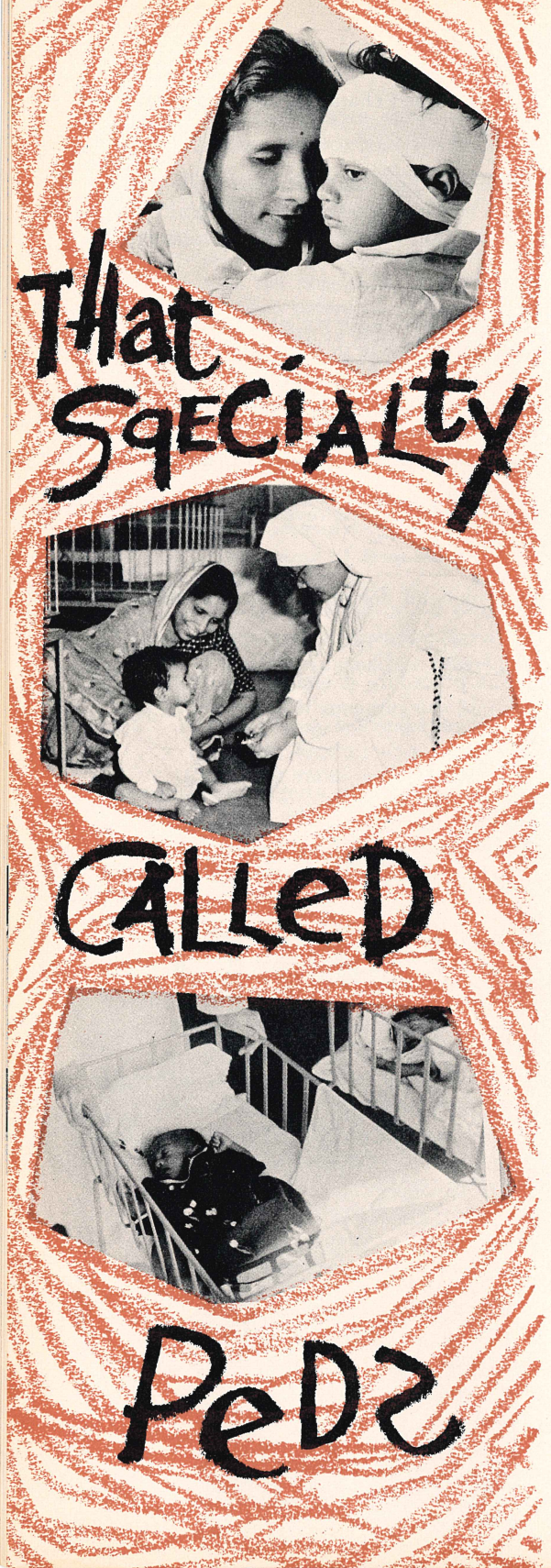
John J. Masterson, M.D., Brooklyn N.Y.

Mr. Hubert Neuhaus, Gelsenkirchen, Germany (Brother of Sr. M. Monica, S.C.M.M.)

Mr. John Olesh, Cleveland, Ohio

Mr. Leon Soulagnet L.I., N.Y.

Mrs. Elizabeth Winkleman, Brinktown, Mo.



"What's your name?"

"Sushila," said one; "Nirmala," ventured another. And "Bimla" volunteered the third. The three seven-year-olds were besmirched with mud, everywhere but in their smiles.

Sister Adelaide and I were down on the river bank with our cameras—watching life on holy Mother Ganges. These three were "helping" us . . . They had come to get clay for the images being made of the goddess Durga for the pujas. I was quite impressed with the weight each little one was able to carry on her head in a basket—roughly 10 pounds I'm sure. Shy of posing at first, in the end they didn't want to leave even when we were out of film. They sat on banana stalks brought over from the other side of the river in little sailboats that spun in the strong tide. They ran to the side of a little calf that ended up getting more than his day's ration of grass while posing. They rushed over to the fishermen and milkmen, and when we left ran up the shore with us. When our guide bought sweets for them in the little bazaar shop, they were at once our friends for life, or at least, until they got tired of walking.

The children of India, like children anywhere, have an appeal of their own. Yesterday I signed the discharge for the fourth of the new-born tetanus babies to go home well. Adequate antitoxin, plus good nursing care, and infinite patience on the part of their mothers, made it

possible. But what a long uphill fight, and the continuous explanation, the "Yes, your son will open his eyes, oh, in maybe three weeks. Yes, he will stop having fits. Yes, he will drink again by himself." For it is almost always a son, and sometimes an only son, who is brought to us with tetanus. The smile on discharge is worth a million dollars —I mean the mother's smile. Perhaps her next baby will even be hospital born!

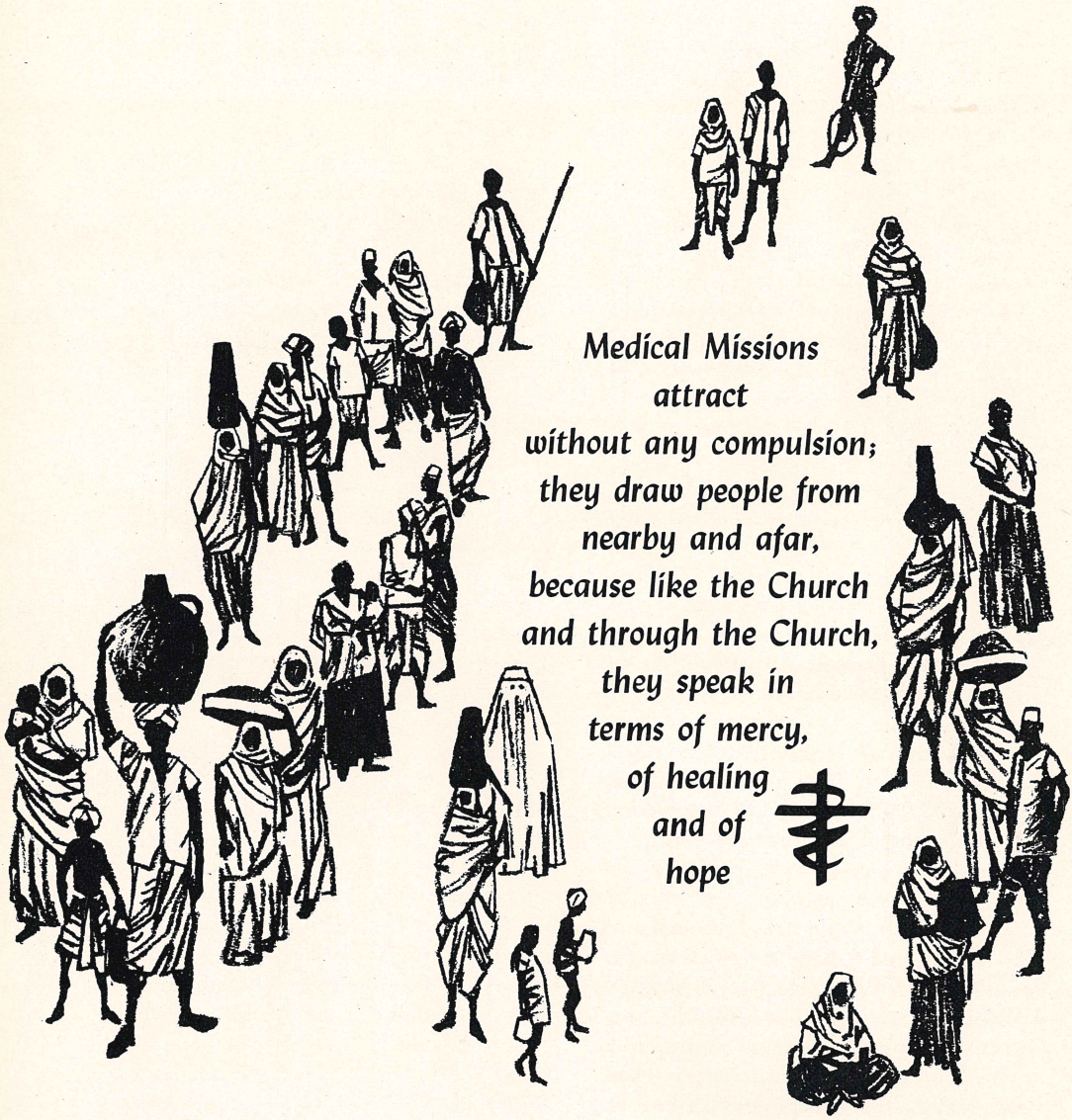
Pediatrics here is an exaggeration of pediatrics anywhere. One of my favorites was "*Khana do.*" His name was really Motilal, but I can never think of him by any other name than *Khana do* —which means, give me food—it is the imperative, not the polite request. Poor little fellow—he came in like a scarecrow, unconscious, with the toxicity and dehydration. He had had an intussusception for over a week. In trepidation we operated, and the day after operation he began the first of many plaintive cries of "*Khana do.*" In fact the first night that we allowed him juice, he fell out of bed trying to get hold of a *bidana* (pomegranate), a sign of real love.

One day, one of my adult patients gave me an orange. My first impulse was to refuse it and then I thought of *Khana do*, so I took it to the youngster, leaving it with him. He was so weak he could not break the skin with either his nails or his teeth. One of the men in the ward, seeing his frustration called me, and as the orange was peeled he literally devoured it. Would that I had had a dozen oranges that day! or any day. Our children are so starved when they come. They are not looking for candy or lollipops when we come on rounds, but just for dry bread! a hard-to-be-believed treat for them.

Most of our pediatric patients these months come with acute broncho-pneumonia or some variant of typhoid. More rarely we see hepatitis, meningitis, and measles. A few weeks ago we had a real rarity — a baby with *erythroblastosis fetalis* (blood disease). So-called Rh babies are rare here, only 3% of the population is Rh-negative as compared with 15% or so in the west. This mother came with her fourth child on his third day of life, with the story that the two previous ones had died of jaundice on the fourth day of life. After 12 hours of arguing, persuading, typing and cross-matching, we finally found an O-negative donor—one of the rick-shaw drivers who is willing to sell blood as a means of supplementing his meagre livelihood. I wonder if he really knows how valuable he is. Without his blood, "Baby" would never have survived. By the time we were able to give the blood by cut-down, I felt like somone who just caught the last train out of nowhere before some catastrophe.

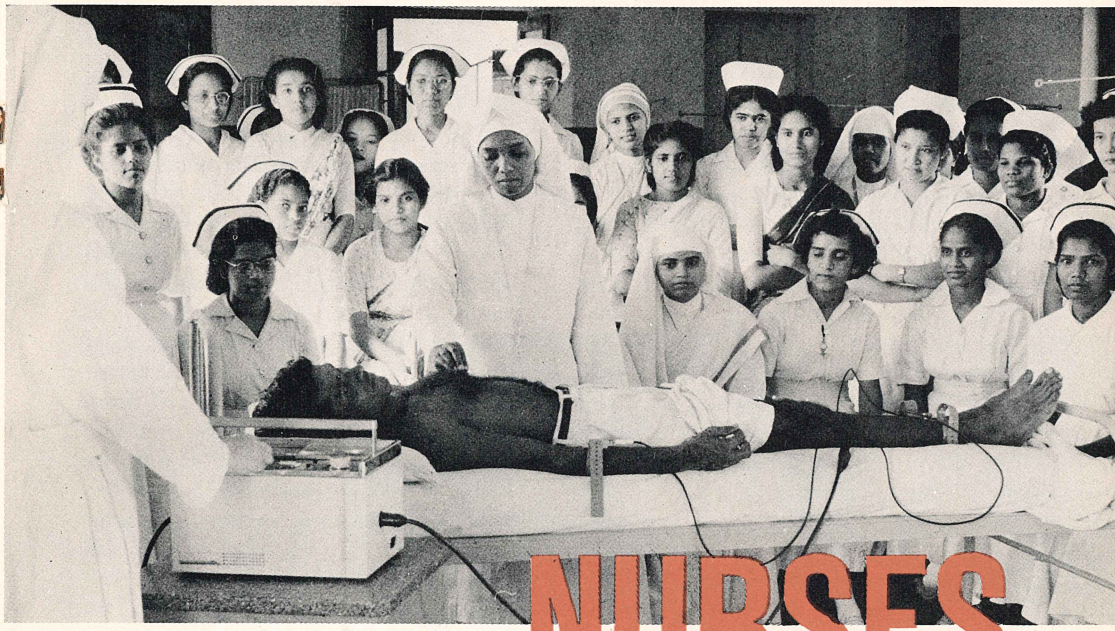
The next morning when our little yellow baby was pink and pretty, it was hard to say who was the happiest. When the mother brought him for his check-up in another week, he was perfect. But what a narrow escape! The history as I give it here sounds like an easy diagnosis, but it was not. The chief complaint was that this baby's mother's milk was no good and it was the mother who was presented first for inspection—the baby was just there because newborns aren't left at home! How to get gray hairs quickly! Just take a medical history literally, instead of imaginatively! That's lesson number 1. Request number 1 here had been for some good powdered milk formula!

Pediatrics as a specialty is only beginning to be recognized and developed here, but it isn't for want of clinical material!


Medical Missions attract without any compulsion; they draw people from nearby and afar, because like the Church and through the Church, they speak in terms of mercy, of healing and of hope

The Medical Mission Sisters have as their apostolate the care of the sick in those parts of the world where the need is greatest. Theirs is a vocation that calls for a large measure of generosity from each individual Sister as she brings healing and hope to the people of India, Ghana, East and West Pakistan, Venezuela, and South Vietnam. Her task, whether as surgeon, nurse, pharmacist, technician, hospital housekeeper or secretary is one of bringing Christ's love to men in a tangible way through the action of her hands and the devotedness of her life thus making real the joyous message of salvation.

TRAINING NURSES in KURJI



by Sister M. Carol

Nursing in India is still bedside nursing and I hope it will always remain so. In Kurji we have a grade A training school approved by and following the syllabus prescribed by the Indian Nursing Council. India's 3rd Five Year Plan has allotted large sums of money to Public Health and given it top priority. Our nursing schools have integrated the Public Health Course into the basic nursing curriculum. There are still so many preventable diseases in India that you can readily see why the government is so concerned about Public Health. We have over 80 students in training, five of whom are male students. They

In the photo above, Sr. M. Carol and Sr. M. F. Therese demonstrate a new Electrocardiograph Machine to some of the students and staff nurses at H.F.H., Kurji. The machine was a gift from a U.S. benefactor.

come from all parts of India—most are from Kerala, but some are from East Bengal, Madya Pradesh, Uttar Pradesh, Bombay, Mangalore, and Bihar. Their dress, features, culture, language and religion are all different—so to blend these students into a harmonious group is not so simple.

Most of our students, about 90%, are Christian. We do have a few Hindu students and Buddhists but, on the whole, Hindus still look down on nursing as a menial service and Muslim girls are usually not educated enough. Rich Hindus will send their daughters to Medical School but rarely ever to nursing schools. Even among the Christians many girls really have to practice humility to carry out all nursing duties. Certain procedures are most repulsive to them and only by seeing us do them, are they able to overcome their revulsion. Some cannot overcome it and so leave. We teach them that they are not defiled by touching what is unclean but rather purify what is impure by offering this service of the sick!

During the first six months of their nursing course they study English, simple nursing procedures, and work on the wards. We have English lesson records, with books explaining them—these are very helpful. But explanations in English are not enough. Just imagine yourself going out to India and immediately being put into a Hindi class with all Hindi explanations! You should see some of the first papers that are turned in—it would take a Master in Linguistics to decipher them!! We explain in Hindi and also use sign language and in about six months most of the group are ready to begin their nursing course! The girls wear white saris and blouses until they are capped. The first time they get into a uniform is really funny. Saris are ankle length and uniforms are 10 inches from the floor so they don't feel dressed and keep pulling their uniforms down. They really look forward to wearing the uniforms but don't know how to walk, sit, or bend in them. We always have drill practice to help them over this difficulty.

This heterogeneous group presents problems and opportunities which a homogeneous one never could. One of India's biggest problems is lack of unity —barriers of caste, religion, and states are real and almost insurmountable. So we have a wonderful opportunity to show that Christianity can and must surmount these differences and merge them all into one. When a girl from Kerala enters the ward for the first time and can't speak a word of Hindi, the Biharis help her translate and teach her what to say. In work, in class, in prayer and in play our nursing students are mixed and by rubbing elbows daily they learn to know and love each other. Differences fade and finally disappear. I've seen a Hindu Bihari girl travel to Kerala, 5 days' journey, to visit a Malayali Catholic friend's family. I've seen a Bihari Christian graduate nurse take a poor Mohammedan nurse's aide home on holidays with her, as she had no family. These are big things in India.

The three year nursing course is all in one Indian textbook. The girls love to memorize it from cover to cover. In the medical world, things are never stationary, so memorizing one book may prove detrimental. Because of this we have to teach the girls how to study. They can easily memorize long tracts, but to understand and digest the material—that is something new for them. To learn to use a library, to use a book index, to refer to several books on a subject—with varying views—this is all virgin territory for our student nurses. New textbooks are being written now in

India to replace the old one-book-text.

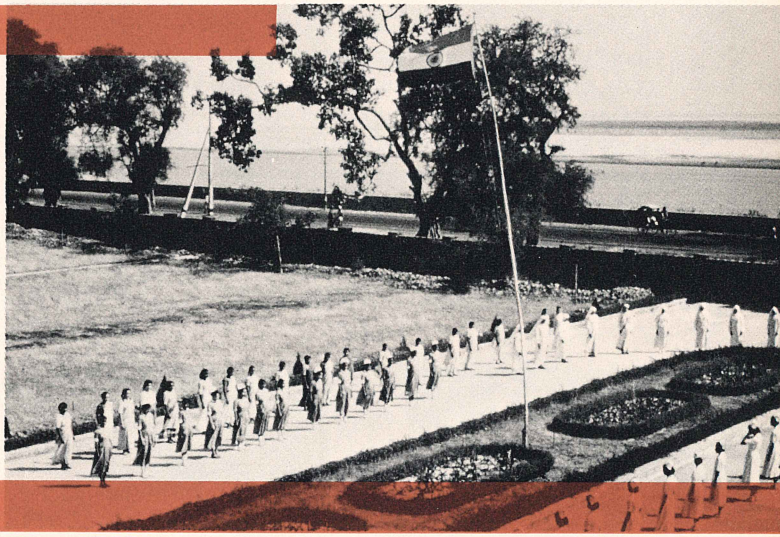
But when after three years of struggle and strife they graduate and get their black velvet band, I know why mothers cry! You go through so much to get them to this stage that you can't quite realize that now they are ready to try their wings. They look so sweet in their graduation uniforms with tiny rosebud corsages and you forget all the heartache seeing them bask in the glory of their big day!

After general nursing, the girls do one year more of Midwifery. We have 24 student midwives now. Most of them are our own graduates of Mandar Holy Family Hospital but some come from other schools also. Most deliveries in India are done by midwives. The doctor is called in only for abnormal or difficult deliveries. Our students attend Moral Guidance Classes during their four year training period. We feel this should fit them with the moral strength needed to fulfill the high demands of their profession. If a nurse does not possess the courage of her convictions in moral matters she is a danger to her profession and to herself.

You have to have strong nerves when you are helping new students and must never sound angry or nervous or the girls will be paralyzed. One day I asked the Midwifery Tutor how one of the new girls was doing. She said, "Oh, she delivered the baby just like a Rashagoola!" (An Indian sweet) how we laughed!

The Midwifery Syllabus requires five home deliveries per student. We do this through our Public Health section. Nearby villages are visited regularly and suitable cases are picked for home deliveries. The girls love to go out, and though it is usually on their free time, the response is greater than the demand! This is a very important work as tetanus in the Newborn can be eliminated in this way. If you should see one child die of tetanus you would be so horrified you would go to any extreme to prevent it ever happening again. The most distressing part about it is that you know it is preventable.

The girls take their nursing seriously.



Republic Day, Jan. 26, nurses assemble in front of hospital for flag raising ceremony. There are 82 nurses in training. Ganges River is in background.

They study hard and work hard. No one ever minds going off duty late if the work load is extra heavy. And they are easy to entertain. A real big treat would be a picnic to a nearby station to join a Corpus Christi procession. They love processions!

Many of our graduates go on for degrees and we encourage this. Right now in Kurji, we are trying to begin a College of Nursing. Our present program is a graduate program as the need is more for graduate nurses who have finished their regular nursing and then decide they want further education. This is preferable because you then can select more easily those who have the best aptitude for the degree course. As soon as we are approved by Patna University, we will begin. We will offer three fields, Public Health, Nursing Education, and Administration. This college program will train experienced and efficient leaders with the qualifications and skills needed to educate better nurses for the future. It should also help to raise the standard of nursing so that all Indians will begin to look up to nursing as the noble profession it is. The need for nurses is very great and by educating more teachers we can train more students. Higher education is greatly desired in India and the fact that nursing graduates also may go on for degrees will encourage many more into the field of nursing.

Our graduates are working in all parts of India—some are also in Canada, England, Germany, and Australia. If we did not have our big modern hospitals, we could not have trained them for this. They are a credit to our training school and we are justly proud of them. When they come to us they seem to be like candles that have not yet been burned. We light the wicks and pray that they will stay burning brightly throughout their lives—wherever they may be—to bring the warmth, light, and love of Christ to all under their care.

Graduation ceremony. Sr. M. Carol lights candles before nurses recite their pledge: "I solemnly pledge myself before God . . . to pass my life in purity and to practice my profession faithfully."

The 1962 Index for the MEDICAL MISSIONARY Magazine available on request. Send 4¢ postage.

WOMEN DOCTORS IN INDIA TODAY

by Dr. Frances Muthana, M.B.B.S.

Within recent years the increasing popularity of the medical profession among Indian women is causing a steady rise in the number of lady doctors graduating every year. But it will be a long time before the demands of the country are fulfilled. The importance and necessity of having enough women doctors can only be comprehended if one is familiar with the mentality of the average woman patient one finds here. Most of the patients I meet, whether rich or poor, would not even look a strange man in the face much less tell him her complaints and even less likely allow him to examine them.

Amusing tales, but nevertheless true ones are told, such as the one of the wealthy *'purdah'* ladies of old who would only allow the court physician to feel her pulse through a piece of string tied around her wrist (at one end). The first practical use of the polygraph one may say! Occasionally when a male doctor is forced to see a female patient she generally fails to give him a complete history and a detailed examination is just out of the question.

In India where more than 75% of the population lives in the rural areas, the health of a good many is in the hands of quacks and those practicing indigenous medicine. The Government is trying to solve the problem by encouraging the younger doctors to work in the villages and many of the country's medical colleges have started a plan whereby all medical students are compelled to work for a definite period in the rural areas after graduation. But until adequate hospital facilities can be provided for everyone, our standard of medical care can hardly compare with that in more advanced countries.

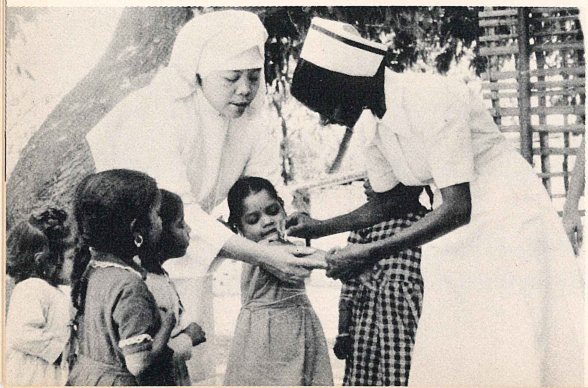
Here, in Bihar, there is a group of people known as Chamars. They were formerly considered an untouchable caste, and it is their women folk, the "chamains," who manage most of the obstetrical cases. Their sense of hygiene is almost nil and their methods of cutting the cord include the use of instruments which may have been used for cutting grass, chopping wood, or even digging the ground. Sterilization and aseptic measures are not even considered, because they are unknown to them. It is no wonder that so many babies die every year from tetanus and so many mothers from puerperal infections. These "chamains" also feel competent enough to handle difficult and complicated cases which would tax the skilled efforts of fully qualified physicians. Only recently a woman was brought to this hospital after she had been hemorrhaging at home for a whole day. Unfortunately, she was dead when she reached here.

Most of the women doctors in India specialize in Obstetrics and Gynaecology, as this is the branch of medicine in which they will get the maximum practice. Of course, there are some who specialize in pediatrics, pathology, anaesthesiology, and radiology, and less commonly, in general medicine, plastic surgery, general surgery, and occasionally in orthopaedics. Most of them work in the towns and are attached to a large hospital or laboratory. But the moment a woman doctor goes out to work in a village, she immediately becomes known as a *lady* doctor and is expected to treat all varieties of women's diseases and is required to be especially competent in obstetrics and gynaecology.

in the indian field with a public health

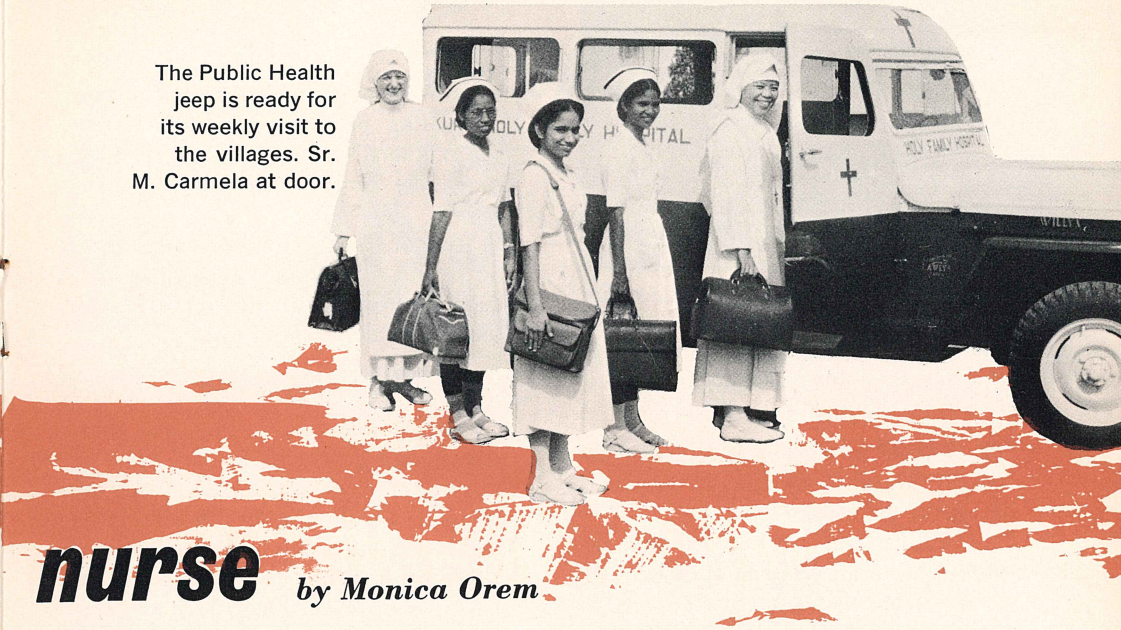
Public Health Clinic in a village. Patients have anemia, smallpox, T.B., malnutrition, and other diseases.

Sr. M. Carmela holds a village child while her student in Public Health Nursing vaccinates the child against smallpox.



Two bicycles passed each other on the road—one frantically waving to the other to stop. Sister M. Carmela, the public health nurse for Kurji Holy Family Hospital, was on her way home. It was hot and dusty and the two nurses in white saris down the road seemed to have a hard time keeping up with her. The boy who was holding her up looked familiar. "Sister, please come to our village—now. Several have died of cholera in the next village and we're afraid." Sister collected her nurses and went with him. They were delighted when they recognized the place. Only last year these very people had refused all inoculations and had run away. So slowly, slowly health education is filtering through the masses, and slowly or quickly these deadly diseases are dying here in India.

The Public Health Nursing Course at Kurji Holy Family Hospital which was set up two years ago in cooperation with the health program of the Government of India has been incorporated into the basic nursing curriculum. The Medical



The Public Health jeep is ready for its weekly visit to the villages. Sr. M. Carmela at door.

nurse

by Monica Orem

Mission Sisters had this course in planning over a period of years. It covers a large field, which in other countries is served by many separate nursing and social agencies.

Since the day Sister Carmela and her nurses sat at a well of a strange village (20 minutes walk from the hospital) with all the doors of the homes closed against them, until they out-waited the curiosity of the women who finally emerged to make friends (one hour later), it was realized that a quicker way of contact was necessary. The local schools were selected as the springboard from which to enter into the homes.

I. School Visiting:

700 children in four schools within 15 minutes walk of the hospital are served by the Kurji nurses. These schools; private, semi-private and government are for the poor village children. A visit is made to each school once a week. The season of the year determines whether the children go to school at 6 a.m. or 10:00 a.m., and whether they are crowded 30-40 into one small dark room lighted by one small window and a door, and sit on the earth floor, or whether they have class outside under the shade of a tree. In any case each child sits cross-legged on the ground with a small table, a slate, and chalk.

1. Each child is given a physical examination periodically. Any abnormalities are referred to a doctor or clinic.

2. Weekly, the staff nurse devotes an hour to health instruction—personal hygiene, nutrition, water, sewage disposal. One of the favorite topics is the life cycle of the fly and mosquito. The children vie with each other to be the one to draw these carriers of disease. The nurse has to be very specific about the size of the drawing—a little fly or a big fly or one which covers the entire blackboard.

3. The teachers are interested in having the premises inspected and suggestions made for improvement. There are no washrooms or sanitary facilities. Drinking water is supplied from a well to which the neighborhood has access.

Weekly, the staff nurses devote an hour to health instruction. One of the favorite topics is the life cycle of the mosquito.

The teacher or teacher and family also usually have their dwelling in the corner of one of the classrooms.

4. Visual aids are needed for improved teaching. One school master was so interested that with Sister's help he managed to get an electrical outlet close enough to show educational moving pictures, provided by U.S.I.S., to the children and the neighborhood.

II. Home Visiting:

The children tell their parents about the nurses who are then welcomed into the village homes. No longer are they considered a source of uncleanness because of the caste system, but rather a visitor bringing God's blessing. Talks and demonstrations on all subjects of public hygiene do not bring too many immediate results but at least there is great interest and the reception is enthusiastic.

III. Domiciliary Midwifery:

After pre-natal check-ups in the hospital, the Public Health Nurses do normal deliveries in the home. Many of these poor people prefer to keep birth a real family affair.

IV. Health Instruction in the Hospital:

In the out-patient department public health staff and students gather groups of waiting patients and teach simple subjects such as baby care, personal hygiene, the necessity of immunization, etc.

Student nurses after leaving the Public Health service are expected to continue the teaching in their contact with patients in the hospital wards.

V. Village Dispensary:

Once a week two doctors, one pharmacist, and the public health nurses go to a dispensary about 12 miles from the hospital. The Public Health jeep takes them over rough country roads. Patients walk in from many surrounding villages and number from 250 to 150 in an afternoon. When necessary, patients are brought to the hospital. Anemia, malnutrition, T.B. and all the problems of childhood are met with.

VI. Follow-up Care of Discharged Patients

The public health nurses go into the homes to do dressings, give injections, check on nutritional problems, teach isolation technique especially for patients suffering from tuberculosis. These patients are all social-economic problems—cases who otherwise would get no medical care.

VII. Immunization:

At regular intervals smallpox, typhoid, and cholera vaccine are administered by public health nurses in:

1. Hospital — to staff, students, patients.
2. Work-shops and factories in vicinity of the hospital.
3. Schools.

No longer is public health nursing on the list of careers not yet open to the average nurse—it is wide, wide open.

BOOKS

Sister M. Fabian

GENERATION OF GIANTS. George H. Dunne Univ. Notre Dame Press, 389 pp. $5.75.

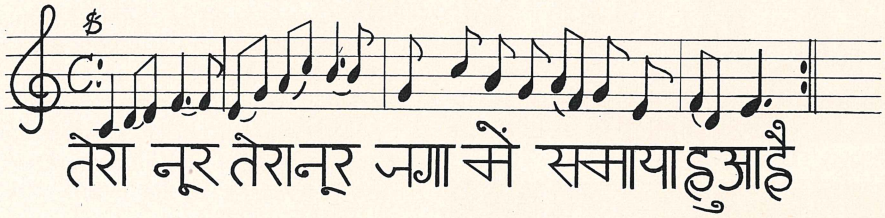
Father Dunne combines within himself several qualifications for his task to describe the mission work of the Jesuits in China in the sixteenth century. He is a Jesuit; he was a missionary in China from before the Second World War until the rise of the communists to power; he is recognized as an historian of more than a little stature. Bringing to bear his knowledge of China from both personal experience and historical training, he has produced at once a serious work of history and a highly readable story of a remarkable adventure in the history of missions.

The early attempts in the sixteenth century of missionaries to penetrate the closed Chinese empire met with total failure. In a great part this was due to the identification of the missionaries with foreign powers under whose protection they entered Macao, the Portuguese enclave on the China mainland. The missionaries, themselves influenced by a Europeanism foreign to the nature of the Church, failed to comprehend the importance of a deep knowledge of Chinese language, customs and culture. The China of that period was a literate, rigidly formalized and stratified society, which placed strong emphasis on scholarship, courtesy, and the tenets of Confucianism. It was the Jesuit, Alessandro Valignano, who gave a new direction to missionary endeavor, by recognizing the necessity for a true understanding and appreciation of the Chinese culture, and by insisting that the men under him learn to speak and write literary Chinese, familiarize themselves with the rules of Chinese etiquette, and become masters of Chinese thought. Only by truly understanding the culture of the people would the missionary be able to adapt what was good in that culture to a Christian Chinese society.

Matteo Ricci was the first of the Jesuits, following Valignano's instructions, to penetrate the mainland, even to the point of establishing a residence in the capital, Peking. Ricci's view of the mission was the long view, and he was content to work slowly, patiently, and carefully to establish Christianity's right to exist in China.

Father Dunne chronicles the work of Ricci and his followers through the last years of the Ming and the first years of the Manchu dynasties. From the first entry of Ruggieri and Ricci into China, through the establishment of Jesuit residences in the main cities, to the point when Adam Schall was to become an adviser to the Chinese emperor, it is a story of great courage and prudence on the part of each of the missionaries. It is the story too of the early converts from among the scholar class, and their contributions to the development of the roots of Christianity in China. These were the men who planted the seed and nurtured it through the early and difficult days, and did so successfully.

indian music



Liturgy

by Mgr. J. Malenfant, O.F.M. CAP.

During the month I spent recently in Kurji Holy Family Hospital, Patna, I witnessed some of the religious and liturgical life in the hospital chapel. I was glad to see that the Sisters sang Gregorian chant. Whatever can be said and done for "vernacular" music and singing in mission countries, Gregorian is, and shall remain, the music of the Church.

But the Sisters, and their nurses, aides, and students, also sang Indian tunes quite well. The Holy See has repeatedly directed us to make use of the cultural and artistic values of each country in our mission life. In particular, it has praised and encouraged the use of the music of each country in religious functions, whenever permissible. The Catholic Hierarchy of India has taken steps for the implementation of these directives. In several dioceses of India the indult has been obtained to sing the Canon of High Mass in Hindi and Indian music. As for devotional hymns and canticles, there are already a good number in use all over the country in each regional language.

Indian music sounds strange to untrained western ears. But, well executed by trained singers, with the accompaniment of some traditional Indian musical instruments, such as the Tablas, it is truly beautiful and deeply touching. Indian Christians feel so much more at home in our churches when singing to God in their own language and music.

In order to sing Indian music properly, it is not enough to be well versed in western music. "Hindustani" music

and the

Miss Krishna Devi Gorg plays the tablas. Indian music well executed by trained singers and accompanied by traditional Indian musical instruments is beautiful and touching.

has delicate peculiarities of its own. An untrained foreigner may learn and sing the tune more or less correctly to his own satisfaction. Yet the effect may be jarring to Indian ears. If we are to sing Indian music in our churches, it should be done in a way that can be appreciated by educated Indians. The same holds good for playing Indian instruments which are the nearly indispensable accompaniment to Indian tunes.

We have been satisfied too long with make-shift adaptations of Indian words to stale foreign tunes, or to Indian popular tunes of dubious taste. There is no longer any excuse for this. Since 1956, there is in North India a "Summer School of Hindustani Music" which has trained hundreds of priests, religious and sisters of a dozen dioceses. The School was founded by Fr. Edmond, O.F.M.Cap., himself an M.A. in Indian music. At the time of his death, December 29, 1961, he was working on his doctoral thesis which was a comparative study of the modal styles of Greek, Gregorian, and Indian music. The school has already published several collections of psalms, liturgical and devotional hymns of high quality, and a few recordings on discs and tape. It also conducts a course of Gregorian music, affiliated to a Benedictine Abbey. Both courses lead to official examinations and diplomas.

Let us hope that all those who have at heart the following of the directives of the Holy See will gradually avail themselves of these facilities.

Across the Medical Mission World

INDIA

First Impressions

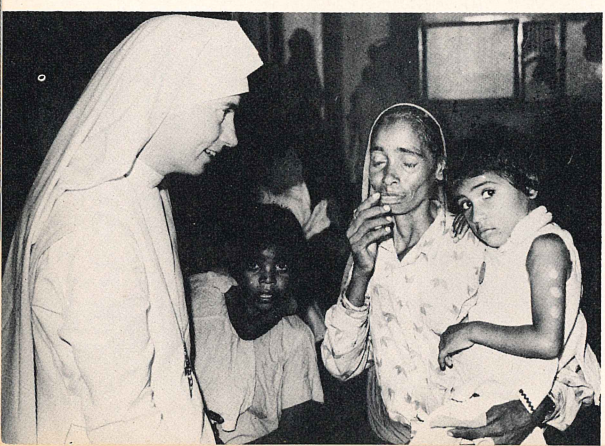
The ride from Palam Airport, Delhi, made a lasting first impression. It was the people, the colorfully-clad people working in the fields, walking along the road, driving bullock carts. On that first day they looked very different, but as days in the Out-Patient Department became weeks the "Shanti's" and "Bimlas" and "Sudesh's" stepped beyond the term "people". They soon became mothers very interested in the health of their children; husbands concerned about their families and work; children eager to eat and play and be loved.

These are the people that make one so grateful for being able to study Hindi. One week I was assigned to take histories in the Ante-natal Clinic. After preparing a list of questions in Hindi, I proceeded to wait for my first customer. The first one spoke "Angrezi" (English). We had a grand old time and the history was recorded! The second lady shook her head at the word "Angrezi" . . . Then I pulled out my trusty list and the unexpected happened! The Hindi worked like a charm bringing forth volumes of useful information . . . but none of which I could understand and, needless to say, record. After a few fruitless *ahsti ahsti* (slowly—slowly) I resorted to an interpreter.

In the hospital compound there are many such contrasts. One day several of us went to visit the *Dhobie* in the laundry set-up. Four men and a boy were waist deep in water in what looked like a small swimming pool made for a definite purpose. The workers were beating the clothes against big rock slabs. Meanwhile four women were spreading the clothes on the ground and letting the sun dry and bleach them. (This did not take such a long time!) The women had many trinkets in their ears and worked so gracefully, in spite of their saris.

Sr. M. Eileen, Holy Family Hospital, New Delhi, India

New Delhi: Sr. M. Eileen in Out-Patient Dept. The lady has no complaints. The little girl is being treated for T.B. gland in the neck.



INDIA

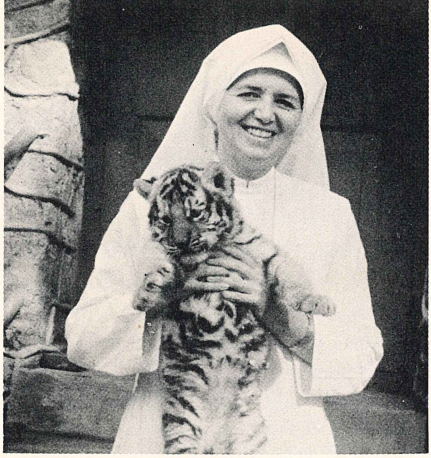
The Lady and the Tiger

It required a bit of self control not to pick up the eighteen pounds of baby tiger and give him a big hug. No longer behind bars next to his mother, Sashi, the five-hundred-pound Siberian tiger from Russia, Umar was stretched out on the camp cot in the Gurkha zoo keeper's room. He had just finished his supper of eight pounds of meat that Sunday evening when Sister M. Carmela and I decided to visit him in his home just above our little house at Northpoint, Darjeeling.

This new zoo in the Himalayas is being built up around the Mountaining School where Tensing Norkey, the co-conqueror of Mt. Everest, is in charge. The park is being prepared gradually and to date the tigers and black bears are the main attraction.

We passed through the room in which Umar was resting into the pit next to the cages in which the big tigers are housed. Both the mother, and Soraiya, the 600-pound father tiger, performed for us at the Gurkha command. They sat up, they lay down, they opened their mouths and showed their teeth. Two younger tigers, each two years old, Radha and Anoo, were in nearby cages. While we were looking at his parents, Umar stood up on the cot and scratched the window glass to tell us he was awake. When we returned to the room, he was down on the floor, and rubbed himself against us like a kitten. He is a real pet and the Nepali boy who feeds him cuddles him in his arms.

Umar is the only one, of the litter of four, whom mama tiger permitted to survive. He is a privileged character and besides his evening meal of meat, he gets powdered milk in the morning. And his boy caretaker informed us he gives him a warm bath daily. At night



Umar, the 8 lb. tiger and the lady! Sr. M. Frederic, Northpoint Zoo, Darjeeling, India. His mother weighed 500 pounds!

Umar sleeps on a pallet on the floor in the corner of the room with the Nepali boy beside him.

Sister M. Adelaide, Kurji
Holy Family Hospital, Patna

S. VIETNAM

Visit to Vietnam's Queen

Sister Maria Fe and I had the opportunity of visiting the Shrine of Our Lady of La-vang—Vietnam's National Shrine. It is in the uppermost province of Free Vietnam, only 35 miles from Hue where we stayed and 17 miles from the 17th parallel.

About 160 years ago, this province was under heavy persecution and the Christians fled to the wooded area of La-vang, even though it was infested with wild tigers and other man-eating animals. They remained there under the almost visible protection of Our Lady who was said to have appeared many times. Each day they would gather to pray her Rosary and thank her for her protection. After three years, the persecutors, having been defeated, the people returned to their own homes. Each year, however, in gratitude and thanksgiving, they would travel to La-vang to pray to Our Lady. First, a small grass

hut chapel was built and finally, a more permanent building.

Yearly, the pilgrims increased and in 1960, President Diem visited the Shrine and placed Vietnam under the protection of Our Lady of La-vang. In 1961, the Holy Father raised the Church to the rank of a Basilica on the occasion of a three-day Marian Congress held there.

Over 100,000 pilgrims from all over the country attended the Congress and the Bishops asked all the faithful to join in begging Our Lady to save the country from Communism, as she had saved the earlier Christians from persecutions.

During this year the Government further honored Our Lady by issuing a postage stamp under the title of Our Lady of La-vang.

Sister M. Karen, Holy Family Hospital, Quinhon, S. Vietnam

PAKISTAN

New Training School

Twelve students are registered for Karachi's initial class in the newly opened Nurses' Training School. Sister M. Brigetta is in charge while Sister M. Martha will direct the midwifery training program.

Sr. M. Martin, Holy Family Hospital, Karachi, W. Pakistan

GHANA

Leprosy Clinics

Here I am writing this, parked in the middle of the Bush. I am spending a few days trekking with Sister M. Francis, M.D., from Kokofu, who is visiting the Leprosy out-clinics. And I do mean "out", fifty to one hundred miles from nowhere. It is really an experience. Tonight we will stay in a Government Rest House high up in the hills with a beautiful view of the valley. As I am writing this, Sister Francis is out under a huge shade tree with about two hundred leprosy patients lined up to be checked and given medicines. Some are selling coconuts, rice, etc., and everyone is chattering like mad.

Sr. Marianne, Holy Family Hospital, Berekum, Ghana

GHANA

Fads and Fashions

Life is quite enjoyable here despite the many sorrows seen in a hospital. We have a large share of joy also and the people themselves are very affable and a joy to be with. They are also a very grateful people.

Just recently we had a large supply of "*Boruni awu*" clothes. *Boruni awu* means "white man has died" and this is the name tagged on to the second-hand European clothes, no matter what their source. We gave out the clothes to our employees, much to their delight. The following day and many days thereafter you would see them appearing in their newly acquired clothes, not always the right fit but they were very proud of them. Some would come with only one sock on because that was all that they had. They explained that this is their privilege and they don't have to wear two socks as is the custom elsewhere.

The other day a man in the village here looked like he belonged to a neighborhood baseball team from home. He had on a grey shirt with ATLANTA written in bright red letters across the back. Another shirt I saw had COZY GRILLE written on it. One can be sure these are very probably American "*Boruni*" clothes.

Sr. M. Malachy, Holy Family Hospital, Techiman, Ghana

Examination Puree

by Sister M. Bertrand

For the past two years our Medical Mission Sisters have been conducting the written, oral, and practical examinations for the Lady Health Visitors (Public Health Nurses) being trained by the Government of India. This training course was centralized for Bihar in Patna City in 1959 when teachers and students numbering 120 moved into two rented houses. The course was organized with the aid of WHO personnel.

To date seventy-four of these students have been given their oral and practical examinations by Sister M. Carmela, who has been organizing the Public Health program in Kurji Holy Family Hospital. In order to improve the dietary habits of the people emphasis is put on nutrition and cookery, and the student must be examined in the home. This prolongs the semi-annual examinations from eight to ten days. With Sister's vivid description of one of these examinations, we can accompany her on a home visit down one of the narrow ancient lanes of Patna City.

Sr. Carmela: (walking down the lane with student). Miss Gupta, have you ever been in the home to which we are going?

Miss G.: No, Sister. For the examination we exchange homes, so I have never met this mother or her baby who has been sick.

Sr. C.: I understand it is a Punjabi family, and you are to teach the mother to cook vegetables, to feed the baby.

Miss G.: Yes, Sister. Here is the house

but there is no one at home! Now I'll fail my examination. (She begins to cry.)

Sr. C.: Don't cry. I'll see that you have your examination tomorrow if not today. But let us wait for a little while.

Miss G.: Oh, there comes the mother down the street with the baby on her hip, and vegetables on her head.

Sr. C.: Where have you been? Didn't you know the nurse was coming to see you at 5:00 p.m.?

Mother: Yes, *memsahib*, but they told me I had to have vegetables for Rajenda so I went to the bazaar to buy them. (They enter a one-room house with a thatched roof and a small shed for a kitchen. The earthen floor room is furnished with a string bed, some household utensils and a small iron frame containing a charcoal fire. The vegetables consist of carrots, eggplant, spinach, and potatoes.)

Sr. C.: Now while we peel the vegetables, you can tell me what you have learned in your public health course. (The oral examination proceeds while Sister and student, seated on tiny wooden stools, about two inches high and slant toward the floor, help the mother prepare the vegetables.) Does Rajenda's mother understand what we are doing?

Miss G.: Oh yes. Explain to Sister?

Mother: The nurse said that, since Rajenda is almost a year old he must have other food beside milk, so she is going to show me how to prepare and feed him vegetables.

Miss G.: Now the vegetables are cooked enough to mash them with a fork.

Sr. C.: But that is not fine enough. What will you use as a strainer?

Miss G.: Here we have a piece of clean cloth through which we press them.

With a spoon the mother feeds Rajenda his pureed vegetables. He gobbles it down smiling and cooing. The nurse is very happy about her successful examination. Mother promises that she will cook for Rajenda every day until he can eat rice and curry.

Sister feels that she has put in a day's hard work and wonders whether next year she will be permitted to examine the students in a Center. But then that would not test the nurse's ability to improvise in these poor homes where one cooking pan is a household treasure, and where "give us this day our daily bread" is a real prayer.

February is Catholic Press Month

Informed Catholics read their Catholic Press

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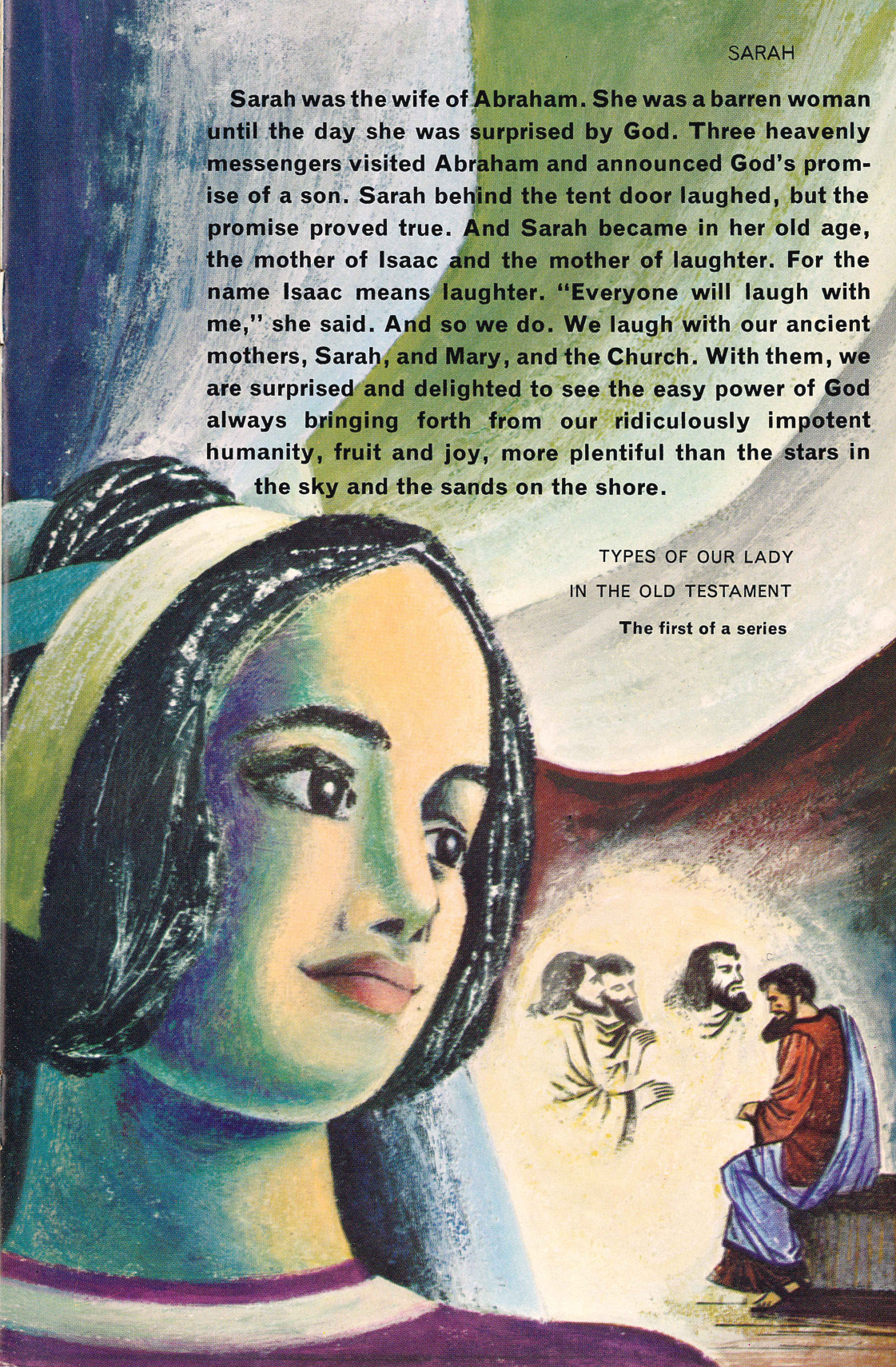
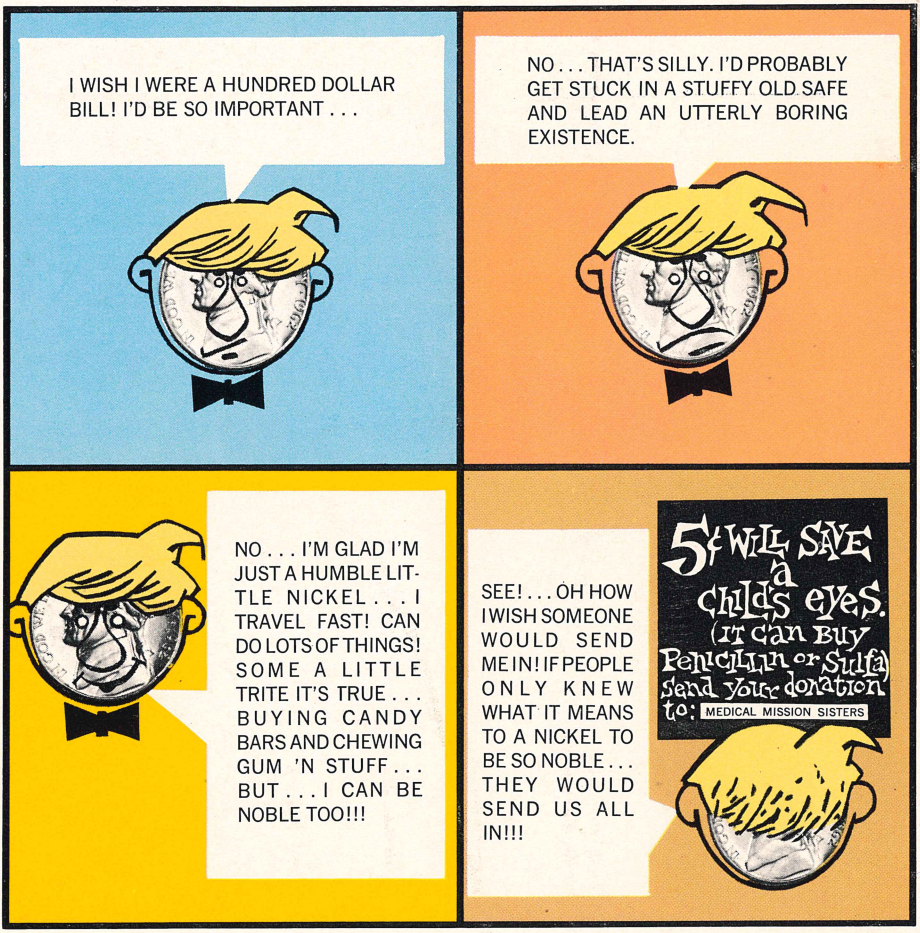


Sarah was the wife of Abraham. She was a barren woman until the day she was surprised by God. Three heavenly messengers visited Abraham and announced God's promise of a son. Sarah behind the tent door laughed, but the promise proved true. And Sarah became in her old age, the mother of Isaac and the mother of laughter. For the name Isaac means laughter. "Everyone will laugh with me," she said. And so we do. We laugh with our ancient mothers, Sarah, and Mary, and the Church. With them, we are surprised and delighted to see the easy power of God always bringing forth from our ridiculously impotent humanity, fruit and joy, more plentiful than the stars in the sky and the sands on the shore.

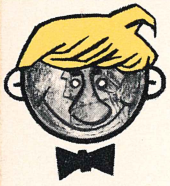
TYPES OF OUR LADY
IN THE OLD TESTAMENT

The first of a series

"Hopes of a Nickel"


I WISH I WERE A HUNDRED DOLLAR BILL! I'D BE SO IMPORTANT . . .
NO . . . THAT'S SILLY. I'D PROBABLY GET STUCK IN A STUFFY OLD SAFE AND LEAD AN UTTERLY BORING EXISTENCE.
NO . . . I'M GLAD I'M JUST A HUMBLE LITTLE NICKEL . . . I TRAVEL FAST! CAN DO LOTS OF THINGS! SOME A LITTLE TRITE IT'S TRUE . . . BUYING CANDY BARS AND CHEWING GUM 'N STUFF . . . BUT . . . I CAN BE NOBLE TOO!!!
SEE! . . . OH HOW I WISH SOMEONE WOULD SEND ME IN! IF PEOPLE ONLY KNEW WHAT IT MEANS TO A NICKEL TO BE SO NOBLE . . . THEY WOULD SEND US ALL IN!!!
5¢ WILL SAVE a CHILD'S EYES. (IT CAN BUY Penicillin or Sulfa) Send your donation to: MEDICAL MISSION SISTERS

Holy Family Hospital, Kurji, India, works to prevent and cure blindness in their public health program. 2,000,000 people in India are afflicted with blindness. 90% is preventable.



MEDICAL MISSION SISTERS, Philadelphia 11, Pa.

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Here are my "noble nickels" $ . . . . . to save many children's eyes in India.

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